State of Alaska
FY2007 Governor's Operating Budget

Department of Health and Social Services
Health Care Services
Results Delivery Unit Budget Summary

Health Care Services Results Delivery Unit

Contribution to Department's Mission

Manage health care coverage for Alaskans in need.

Core Services

- Provide access to appropriate health care services; and
- Assure access to a full range of health care service information to our customers.

The Division of Health Care Services (HCS) maintains the Medicaid core services by:

- Hospitals, physician services, pharmacy, dental services, transportation, physical, occupational, and speech therapy;
- Laboratory and x-ray;
- Durable medical equipment; and
- Hospice and home health care

Departmentwide, HCS administers the State Children's Health Insurance Program (SCHIP), the Medicaid Management Information System (MMIS), claims payments and accounting, third-party liability collections and recoveries, federal reporting activities, Medicaid Administrative Claiming, Medicaid Error Rate program, and the Chronic and Acute Medical Assistance program.

HCS also administers the following programs:

- Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program. The EPSDT program assures that children enrolled in Medicaid receive preventative health care and additional diagnosis or treatment services as needed. Good quality preventative health care reduces subsequent medical care costs for these children. All Medicaid Services/EPSDT program activities are directed toward addressing federal EPSDT regulations and related federal initiatives. The program sends notice to parents or guardians of children due for well-child exams and immunizations; assists families in finding physicians, nurse practitioners, dentists and vision care providers, in their home community who accept new Medicaid patients; coordinates and funds transportation reimbursement to preventative health care appointments for children and pregnant women. Reimbursement assistance is available for health care appointments if the family would not otherwise be able to afford to attend the appointment.

- The Chronic and Acute Medical Assistance Program (CAMA). The CAMA program provides a limited package of health services to those individuals with chronic medical conditions who do not qualify for the Medicaid program. CAMA's limited benefits are only available to low-income persons with an immediate need for medical care who are unable to secure other private or public assistance.

- Tribal Health Agenda. The HCS is playing an integral role in the Tribal Health Agenda spearheaded by the Office of Program Review. Projects with tasks falling to HCS include development of policy that will enable tribes to bill for services under management contracts, review of new estate recovery policy, ensuring tribes that provide public health nursing services are included in the plan for Medicaid reimbursement, providing administrative, training and claims processing services for Tribal Medicaid Administrative Claims (Tribal MAC) agreements, providing support for data analysis, reporting, and training of tribes, and the development of "due" lists to support tribes who have continuing care provider agreements.

End Results	Strategies to Achieve Results
A: Mitigate Health Care Services (HCS) service	**A1: Increase Indian health services (IHS)**

reductions by replacing general funds with alternate funds. Target #1: Reduce by 1% the GF expenses replacing them with alternate funds. Measure #1: Percent of general funds replaced with alternate funding.	**participation by 5% in expenditures.** Target #1: Increase Indian health services (IHS) participation by 5% in expenditures. Measure #1: Change in percentage of IHS participation. **A2: Expand fund recovery efforts.** Target #1: Increase funds recovered by 2%. Measure #1: Change in amount of funds recovered.
End Results	**Strategies to Achieve Results**
B: To provide affordable access to quality health care services to eligible Alaskans. Target #1: Increase by 2% the number of providers enrolled. Measure #1: Change in number of providers enrolled.	**B1: Improve time for claim payment.** Target #1: Decrease by .5% the average time HCS takes to pay a claim. Measure #1: Change in the average time HCS takes to pay a claim. **B2: Improve payment efficiency.** Target #1: Increase the % of error-free claims by .5%. Measure #1: Percent of error-free claims by service type.

FY2007 Resources Allocated to Achieve Results

FY2007 Results Delivery Unit Budget: $774,105,700

Personnel:	
Full time	51
Part time	0
Total	51

Performance Measure Detail

A: Result - Mitigate Health Care Services (HCS) service reductions by replacing general funds with alternate funds.

Target #1: Reduce by 1% the GF expenses replacing them with alternate funds.
Measure #1: Percent of general funds replaced with alternate funding.

HCS Medicaid Actuals - Other Funds (in millions)

Year	% Federal	% General	% Other
1999	66.0%	34.7%	.8%
2000	65.3%	25.5%	9.2%
2001	66.4%	22.7%	10.9%
2002	66.6%	27.8%	6.1%
2003	67.5%	25.5%	7.1%
2004	71.1%	16.6%	12.4%
2005	71.5%	17.5%	11.0%

Analysis of results and challenges: Seek ways to maximize federal participation through Family Planning, IHS, BCC, and Title XXI expenditures.

Charted numbers represent actual expenditures recorded in ABS as percentages. Note FY04 is the first year reported after the reorganization. Prior year actuals will include the complete Medicaid Program and therefore do not provide exact comparisons between fiscal years.

A1: Strategy - Increase Indian health services (IHS) participation by 5% in expenditures.

Target #1: Increase Indian health services (IHS) participation by 5% in expenditures.
Measure #1: Change in percentage of IHS participation.

Health Care Services IHS Participation (in millions)

Year	Total Exp	IHS	% of Total	% Increase
1999	228.6	37.5	16%	
2000	268.4	49.4	18%	2%
2001	323.0	73.3	23%	5%
2002	385.9	89.3	23%	0%
2003	466.6	134.9	29%	6%
2004	503.6	154.5	31%	2%
2005	558.2	177.8	32%	1%

Source: Total Expenditures include all direct services claim payments in HCS Medicaid less drug rebates. Direct services claim payments, including FairShare claims, are from MMIS-JUCE. The drug rebate offset is from AKSAS.

DHSS, FMS, Medicaid Budget Group using AKSAS and MMIS-JUCE data.

Analysis of results and challenges: The Department of Health & Social Services has created a unit dedicated to working with Tribal organizations to maximize IHS federal fund participation in the Medicaid Program and to assure Native beneficiary access to a continuum of care through Tribal health services. Some of the work in progress includes the transition of services in the YKHC Delta to the Tribal health care system while sustaining funding for these services during this transition; maximization and improvement to the Medicaid billing capacity of Tribal organizations; and assistance to Tribal health organizations in the expansion of community-based services in addition to primary care.

A2: Strategy - Expand fund recovery efforts.

Target #1: Increase funds recovered by 2%.
Measure #1: Change in amount of funds recovered.

Medicaid Recoveries: Drug Rebates & Third Party Liability Collections (in millions)

Year	Drug Rebates	TPL	Total	% Increase
2003	17.0	8.0	25.0	N/A
2004	19.4 +14.12%	10.1 +26.25%	29.5 +18.00%	18%
2005	30.2 +55.67%	8.7 -13.86%	38.9 +31.86%	24%

Analysis of results and challenges: Health Care Services has been able to increase collections on drug rebates and third-party liability by 24% from FY2004 to FY2005. Efforts continue to enhance contracted services as well as in-house collections.

B: Result - To provide affordable access to quality health care services to eligible Alaskans.

Target #1: Increase by 2% the number of providers enrolled.
Measure #1: Change in number of providers enrolled.

Number of Providers in Selected Provider Types Enrolled in Medicaid

	FY2003	FY2004	FY2005	YTD FY2006	Same Time Last FY (05)
Physicians	6,440	7,076	6,486	5,365	5,487
Dentists	587	597	578	501	517
Pharmacies	359	356	287	206	263
Hospitals	734	841	739	605	598
Nursing Facilities	36	33	29	29	28
Sum	8,156	8,903	8,119	6,706	6,893

Source: MARS MR-0-06-T

Analysis of results and challenges: The number of providers of selected types enrolled in Medicaid declined by 17.4% from the end of FY05 to the end of the first quarter of FY06 (YTD). The decline was less, 9.7% when the same point in FY 2005 (end of the first quarter) is compared to FY 2006 year-to-date.

Provider enrollment is difficult to compare year-to-year for a variety of reasons.

a) Provider enrollment and participation in the Alaska Medical Assistance programs is voluntary; providers may choose to end their enrollment at any time and do so for various reasons.
b) The time limit for submission of claims is one year from the date services were rendered and some providers wait many months to bill, which may be a factor in participation and enrollment from year to year.
c) Out-of-state providers may be prompted to enroll when they see an Alaska Medicaid client or when they attempt to bill for the services rendered to our clients. These providers typically cease to participate and/or maintain their enrollment status once the few claims have been paid for these out-of-state health care encounters.
d) In the prior division and structure, DMA included a unit dedicated to provider and beneficiary customer service. Within that unit, the Participation and Access Coordinator was tasked with ensuring adequate provider participation in the Medical Assistance programs through the analysis of provider enrollment activities. Management and staff functions responsible for administration of the Medical Assistance programs changed in DHSS at the time of reorganization. There is presently no one individual tracking all provider types.
e) In response to the following Legislative Audit finding contained in a letter dated February 18, 2003, the department instituted procedures whereby providers who do not submit claims in 18 months or longer are placed in an inactive status.
1) Audit Finding: "Almost half of the providers, currently active in MMIS, have had no claim activity for more than a year....these numerous active members increase MMIS's susceptibility to fraudulent claim submissions...DMA should regularly inactivate unused provider numbers."
2) Response: There have been two major efforts to identify providers in all provider types which were without claim activity for 18 months or longer and place them in an inactive status. Result was that 1,375 providers were inactivated in September 2003; 1,271 providers were inactivated in October 2004.

In prior reporting periods, results for this measure included data for both provider enrollment and participation for the selected provider types. Since the measure is stated in terms of enrollment and provider participation is voluntary a decision was made to change the measure analysis methodology and discontinue use of

participation data.

There are other differences in the way this measure is reported for FY 2006. Provider enrollment data for FY 2006 includes both in-state and out-of-state providers, while the data for previous years was restricted to in-state. Use of in-state provider data was linked to the use of occupational licensing data, which has also been discontinued this year. Some providers are not required to be licensed in Alaska, which caused discrepancies in the reported data. The analysis at the end of FY2005 included the following statement:

A single professional license may be the basis for multiple Medicaid provider id's. For example, a physician with a private practice may also be a member of a hospital physicians group or a member of a clinic or other group practice, and would have a separate Medicaid provider id for each. Methodology used to produce the 2005 data for this performance measure produced one unduplicated count for each professional license provided by Occupational Licensing that matched license data on MMIS provider records. Data does not represent the number of unique provider ids used for claims billing or the number of locations where services were provided.

Differences in enrollment reported for 2004 and 2005 may be influenced by methodology. We used the last documented methodology and were unable to duplicate data previously reported for 2004. Data for 2003 and 2004 is presented as previously published.

Since we observe less of a decline from FY 2005 to FY 2006 when we compare the same point in time during each year, it is reasonable to expect that the number of enrolled providers may continue to increase during FY 2006 to reach a level close to that which was reached at the end of FY 2005.

B1: Strategy - Improve time for claim payment.

Target #1: Decrease by .5% the average time HCS takes to pay a claim.
Measure #1: Change in the average time HCS takes to pay a claim.

Analysis of results and challenges: This measure is reported at the department level.

B2: Strategy - Improve payment efficiency.

Target #1: Increase the % of error-free claims by .5%.
Measure #1: Percent of error-free claims by service type.

Error Distribution Analysis – Percent Claims Paid with No Errors by Primary Providers[1]

	FY01	FY02	FY03	FY04	FY05	Year-to-Date FY06
Total Claims Paid (fiscal year) [2]	3,670,331	4,202,677	4,776,730	5,186,692	6,150,027	1,614,369
Percent Paid with No Errors (total claims)	72.64%	74.43%	73.46%	76.33%	72.15%	73.60%
Hospitals	57.45%	60.29%	64.71%	63.55%	64.52%	65.13%
Physicians	69.01%	67.40%	65.39%	63.94$	62.94%	64.58%
Dentists	72.96%	73.24%	74.35%	74.28%	73.26%	78.39%
Nursing Home Facilities	69.75%	65.28%	61.80%	61.68%	48.52%	47.14%
Pharmacy	80.23%	83.34%	80.13%	77.45%	76.51%	76.58%
Mental Health	70.28%	72.67%	75.55%	76.94%	73.56%	71.64%
Transportation	88.84%	87.89%	86.12%	86.36%	74.80%	80.57%
HCBC	73.27%	76.94%	78.16%	80.65%	86.59%	87.20%
Vision	82.89%	79.73%	76.67%	68.57%	76.47%	83.47%
Psych	68.67%	70.05%	42.36%	46.57%	55.13%	58.72%
Clinics	64.78%	96.25%	57.92%	48.26%	65.44%	64.47%
BRS	87.16%	91.15%	86.32%	84.25%	87.44%	81.29%
Chiropractic	60.68%	60.09%	48.76%	51.30%	53.29%	54.27%

Notes
[1] Between FY01 and FY03 reports were based on six months of data. The FY04 and FY05 reports were based on annual data. The FY06 reports are year-to-date data from the September summary. Source: MARS MR0-117.

[2] 206,400 of the total claims are from provider types not listed above. These claims are from "Other" provider types such as DME (durable medical equipment) and therapy (physical, speech, and occupational).

Analysis of results and challenges: The percent of claims paid without error increased from FY2005 to the

first quarter of FY2006. The error-free percentage gained one and one-half points, from 72.15% in FY 2005 to 73.60% in the first quarter of FY 2006. The FY 2006 year-to-date percent of claims paid without error showed improvement over FY 2005 in the following eight areas: Hospitals, Physicians, Dentists, Pharmacy, Transportation, Vision, Psychiatric, and Chiropractic. Five areas showed a decline in the error-free percentage (Nursing Home Facilities, Mental Health, HCBC, Clinics, and BRS). The highest error-free rate was HCBC, at 87.20% (despite a slight decline during the reporting period), while Nursing Home Facilities was lowest at 47.14%. Six areas have error-free rates above 75% year-to-date: Dentists, Pharmacy, Transportation, HCBC, Vision, and BRS. Only one area, Nursing Home Facilities, has an error-free rate below 50%.

Key RDU Challenges

The goals of the organization are to bring financial stability to operations, maximize federal funds, provide more accountability in program management, and improve quality and customer service. Continued program alignment will balance cost effectiveness and service delivery and improve services to clients. This realignment of duties and responsibilities remains a challenge in FY06 and FY07.

Transportation. The State Travel Office began booking Medicaid Recipient travel for all non-emergent, medically necessary travel on 1/1/05. The State Travel Office receives an average of 1,921 calls and processes travel for an average of 1,479 travelers each week.

Medicaid Management Information System Development Project. Federal law requires all states participating in the Medicaid program to operate an automated claims processing system which must be certified by the federal government as a Medicaid Management Information System (MMIS). Federal rules also require these fiscal agent contracts be competitively bid. The contract for HCS's current fiscal agent was negotiated and awarded in May 1987.

A priority goal for the division is to transition to a new MMIS system with minimum disruption to its service providers and clients. The new system must satisfy the needs of the state, medical service providers and the clients they serve.

Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program. Reducing future medical costs by increasing the quality of preventative medical services for children without increasing current care reimbursement levels; providing new, cost effective vaccines to teenagers who are a "devil-may-care group" known for avoiding doctors; and, providing parents with targeted, age appropriate well-child exam and immunization information they need to protect the health of their children.

Recipient Services. Challenges to the recipient services program include educating and preparing "dual eligibles" (individuals eligible for both Medicaid and Medicare) for the new Medicare Part D drug benefit plan. Educational materials have been developed and distributed, and networks of volunteers are trained to provide information and assist dual eligibles to enroll in a drug plan beneficial to them.

Alaska Medicaid Preferred Drug List (PDL). A PDL is a list of prescription medications within a therapeutic class that represents Medicaid's first choice when prescribing for Medicaid patients. Pharmacy growth costs have averaged up to 27% over the past several years. To help control these costs, HCS has implemented a PDL for Medicaid beneficiaries as a cost containment measure consistent with our desire to maintain Medicaid services and eligibility to the greatest extent possible. The PDL allows the state to manage the drug program by improving capacity and effectiveness as purchasers of pharmaceuticals and align the patient need, the physicians' knowledge, and the state's purchasing power. Alaska Medicaid participates in the National Medicaid Pooling Initiative to obtain the best rebates available for the drugs that are included on the PDL.

The success of a PDL takes cooperation from providers and prescribers. The Pharmaceutical and Therapeutics (P&T) Committee is responsible for determining if the drugs within a therapeutic class exhibit a class effect and are therapeutically equivalent. The P&T Committee is comprised of a group of Alaskan medical professionals who prescribe or dispense prescription drugs. The committee has statewide representation and includes various physician specialties, pharmacists, dentists, and a nurse practitioner. The sub-committee of psychiatrists was used when the department reviewed mental health drugs.

Implementation was based on a phase-in approach whereby drug classes are added to the PDL over a period of time. Public input has primarily been related to the program's continued, uninterrupted access to specific brand drugs which have clearly proven beneficial to the patient. The program design meets this need.

Surveillance, Utilization & Review. HCS is committed to an aggressive recruitment and retention effort to build and sustain a highly competent resource infrastructure with substantive program and business management expertise and depth. This will assure the state continues to enjoy the benefits of a service delivery system of the highest caliber, and well-managed, comprehensive and consistent health program policy under an aggressive cost containment strategy.

Expanding healthcare service programs and federal mandates have required HCS to focus on preparedness and training to meet the needs associated with these changes. HCS has been instrumental in working on the Payment Error Rate Measurement grant project and is preparing for the new Medicaid Error Rate federal regulations.

In order to more effectively respond to increased Federal and State interest in pursuing fraudulent providers the Department has established within the Commissioners Office a contact individual to address issues and requests from the Medicaid Fraud Control Unit and the Federal Office of the Inspector General.

Increased emphasis on curbing fraudulent and abusive behavior has also led the Department to establish a high level Audit Committee to assure consistent and effective Program Integrity efforts.

Administration of the Medicaid Program and Chronic and Acute Medical Assistance (CAMA). Programmatic and financial responsibility for Medicaid services and for CAMA are housed under the RDU whose customers are the major users of the services: Medicaid funding for mental health related services are housed in the Behavioral Health Medicaid Services component; Behavioral Rehabilitation Services are housed in the Children's Medicaid Services component; and funding for nursing homes, personal care, and waivered services are housed in the Senior and Disabilities Medicaid Services component. Oversight of the program as a whole is under the umbrella of the Commissioner's Office with the Office of Program Review and the Office of Rate Review. HCS maintains the operations aspects of the programs, i.e., claims payments; contract management; provider, facility and client services.

Significant Changes in Results to be Delivered in FY2007

New development work began in FY06 to implement third party insurance cost avoidance rules and prepare the pharmacy claims processing system for the Medicare Part D program. A new Medicare Part D prescription drug benefit available to all Medicare recipients becomes effective January 1, 2006. States' direct spending on drugs for dual eligibles will decrease, but savings are offset by the states' phased-down contribution known as the clawback. The clawback is a provision of the new law requiring states to pay the federal government according to a formula intended to estimate those savings. States will then be required to pay 90% of the estimated savings in the first year, phasing down in subsequent years.

Major RDU Accomplishments in 2005

The EPSDT Program experienced two major accomplishments this last year. First, we increased the ratio of actual preventative health exams to a desired number of exams for the fourth year in a row, by almost 3% for the year; and secondly we increased the percent of children receiving at least one needed preventative health exam from 56.8% to 58.0%.
The CAMA program provided payment for 1,046 individuals within the appropriated general fund amount in FY2005 through regulations that reduced services provided and aggressive management of claiming adjustments for payments made by CAMA for individuals who become Medicaid eligible. This was necessary to stay within the reduced budget allowed for CAMA in FY04 and carried through FY05.

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Health Care Services
RDU Financial Summary by Component

All dollars shown in thousands

	FY2005 Actuals				FY2006 Management Plan				FY2007 Governor			
	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds
Formula Expenditures												
Medicaid Services	115,773.8	449,836.3	61,649.2	627,259.3	115,431.9	463,741.6	76,874.0	656,047.5	190,460.3	521,477.3	32,030.3	743,967.9
Catastrophic & Chronic Illness	1,470.9	0.0	0.0	1,470.9	1,471.0	0.0	0.0	1,471.0	1,471.0	0.0	0.0	1,471.0
Non-Formula Expenditures												
Medical Assistance Admin.	1,155.5	2,950.5	553.4	4,659.4	8,548.0	21,277.2	217.3	30,042.5	8,210.1	20,262.4	194.3	28,666.8
Health Purchasing Group	4,272.7	10,859.4	0.0	15,132.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Women's and Adolescents Services	467.8	3,188.1	69.2	3,725.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Hearings and Appeals	227.6	81.7	74.0	383.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Totals	**123,368.3**	**466,916.0**	**62,345.8**	**652,630.1**	**125,450.9**	**485,018.8**	**77,091.3**	**687,561.0**	**200,141.4**	**541,739.7**	**32,224.6**	**774,105.7**

Health Care Services
Summary of RDU Budget Changes by Component
From FY2006 Management Plan to FY2007 Governor

All dollars shown in thousands

	General Funds	Federal Funds	Other Funds	Total Funds
FY2006 Management Plan	**125,450.9**	**485,018.8**	**77,091.3**	**687,561.0**
Adjustments which will continue current level of service:				
-Medicaid Services	1,413.6	-1,413.6	0.0	0.0
-Medical Assistance Admin.	-352.9	-1,045.8	-23.0	-1,421.7
Proposed budget decreases:				
-Medicaid Services	-646.7	-17,535.0	-45,000.0	-63,181.7
Proposed budget increases:				
-Medicaid Services	74,261.5	76,684.3	156.3	151,102.1
-Medical Assistance Admin.	15.0	31.0	0.0	46.0
FY2007 Governor	**200,141.4**	**541,739.7**	**32,224.6**	**774,105.7**